Method: 359 trainees across all subspecialties and UK regions were surveyed in 2011 regarding ISCP, compared to 539 users surveyed in 2008. 5-point scales were analysed using chi-squared tests.

Results: 79% used ISCP, 38% elogbook and 5% OCAP. 201 responders (56%) evaluated ISCP v8. 59% had registered before 2008 and 31% since. Modal ratings were ‘average’ throughout, with the following percentages of responders rating ‘poor’ or worse versus ‘good’ or better the domains: registration 12% vs 35%; assessments 36% vs 22%; peer assessment tool 34% vs 25%; recording meetings 34% vs 19%; helpdesk 11% vs 40%. Trainees were neutral about training impact and 44% thought ISCP was needed. Statistically significant (p<0.001) improvements were seen in satisfaction throughout domains comparing v8 to v5.

Conclusions: While satisfaction with ISCP has improved significantly during the last 3 years and its registration and helpdesk support are considered good, its assessment and meeting recording features remain average or worse. Increased satisfaction and ISCP’s perceived necessity may reflect an increased proportion of respondents who commenced training after its introduction.

0697: PRESCRIBING FOR SURGICAL PATIENTS COMPARED TO OVERALL PRESCRIBING SKILLS OF FOUNDATION YEAR 1 DOCTORS: A STUDY BY THE AVOIDING PRESCRIBING ERRORS (APE) COMMITTEE

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Aim: Prescribing errors are the most common type of medical error. Foundation Year 1 doctors (FY1s) are, according to recent research (1), responsible for 37.8% of these. We aimed to assess, using a validated instrument, the probability of wrong prescribing in common surgical medications (analgesia, antibiotics, anticoagulation) among FY1 doctors.

Methods: When starting in Croydon University Hospital, FY1 doctors take a prescribing test. We analysed 195 tests (over a period of 5 years). The 13 questions in this test were analysed to identify areas for improvement by an Avoiding Prescribing Errors (APE) committee which convenes monthly, led by FY1s supported by senior doctors and pharmacists.

Results: Logistic regression showed a statistical significant difference between cohorts in prescribing of opioids (41% correct answers, p<0.001) and penicillins (73% correct answers, p<0.001) but not warfarin (89% correct answers, p=0.34). Correlation coefficients were r=0.59, r=0.30 and r=0.34 respectively. There is a significant difference between pre-2010 cohorts (when formal prescribing skills teaching was implemented in medical schools, following the EQUIP study) and later cohorts.

Conclusions: There is no difference in prescribing skill in surgical mediations and overall prescribing skill. Between cohorts, there is an improvement after 2010.


0700: HOURS AND SURGICAL TRAINING: THE ELEPHANT IN THE ROOM LIVES ON

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Aim: Our aim was to assess the current impact of working hours on surgical training and explore ways in which any problems may be addressed in the future.

Method: 359 trainees across all subspecialties and UK regions were surveyed in 2011 regarding working hours.

Results: A majority of respondents worked in excess of the legal 48 hour limit (81.1%) with the majority of these working in the 48–60 hour (57%) and 60–70 (36.6%) hour brackets respectively. The most common reason was to gain sufficient training exposure (48.2%), followed by service commitments with no rota gaps (28.1%) and service commitments due to rota gaps (12.5%). The vast majority of trainees were prepared to work extra hours (93.2%). The most frequent responses were 48–60 hours (39.9%) and 60–70 hours (31.1%).

Conclusions: The survey results confirm that the vast majority of surgical trainees would be willing to work extra hours beyond the artificial 48 hour limit, and a large number are already working extra hours in order to obtain adequate training. Increasing hours to a happy medium of around 60 hours per week in combination with improving the regulated training content of jobs appears a workable solution to the EWTD conundrum.

0706: A QUANTITATIVE ANALYSIS OF YOUTUBE AS A RESOURCE FOR SURGICAL EDUCATION

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Aim: To assess the availability of Youtube videos for each surgical specialty PBA.

Method: A list of the PBAs for all 9 surgical subspecialties was extracted from www.iscp.ac.uk. Search terms were derived from the PBA titles for each procedure excluding potentially nebulous terms. Youtube searches were conducted using the derived terms and the number of video results was recorded. The results were recorded an analysed in Microsoft Excel.

Results: 92.6% of PBAs were available online. Specialties were ranked according to video/procedure. The top ranked subspecialty was OMF Surgery (875.5 videos/procedure), the lowest total number and the highest number of procedures with zero videos was Urology (35.6 videos/procedure; 8/53).

0715: THE QUALITY OF BLOOD TRANSFUSION DOCUMENTATION AND CONSENT IN SURGICAL PATIENTS AT A CENTRAL LONDON TEACHING HOSPITAL. WHAT SHOULD WE BE TEACHING TO MAINTAIN GOOD TRANSFUSION PRACTICE?

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Introduction: Accurate record keeping is a crucial component of good medical practice and blood transfusion documentation in surgical patients is essential for patient safety. There are also concerns about the level of information and consent of the patients. This study assesses the adherence to standards and quality of medical records on blood transfusion and the level of consent obtained.

Methods: We analysed the records for 108 transfusions performed at a Central London Teaching Hospital. All the patients were asked whether they gave written or verbal consent prior to transfusion of packed red cells and whether they received a blood transfusion information leaflet.

Results: Of the 108 patients, pre-Hb was documented in 65 patients (60.2%), indication in 38 (35.2%), consent in 2 (1.8%) and post-Hb in 48 (44.4%). Verbal consent was given in 27% and leaflets were received by 4%.

Conclusion: We have shown the quality of blood transfusion record keeping and consenting to be poor. This has major safety and legal implications, exacerbated by the EWTD and the ever increasing number of patient handovers. We propose compulsory transfusion teaching to include record keeping and consenting as an education tool for junior doctors. In addition, provision of leaflets must become routine.

0728: TEAM-BASED STRUCTURE WITHIN DEPARTMENT INCREASES TRAINING OPPORTUNITIES FOR JUNIOR TRAINEES

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Aims: Service provision and training of junior surgeons is a difficult balance. Working hours are limited by European Working Time Directives (EWTD). We implemented a change to the plastics surgery department senior house officer (SHO) rota to allow trainees to work in a consultant team-based structure; in order to maximise training opportunities and meet the learning requirements set by the Joint Committee on Surgical Training (JCST). The aim of this study is to assess if this change has improved learning opportunities for senior house officers (SHOs) in plastic surgery.

Methods: Retrospective review of the weekly rota for three weeks before and after the change implementation. The number of theatre sessions and outpatient clinics attended by SHOs was recorded.

Results: Four core trainees (CT), two foundation year 2 (F2) and two junior specialty doctors (JSD) were included in the study. Prior to the change; eight